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January 25, 2011

Statement
Of
Anthem Blue Cross and Blue Shield
On
SB 16 An Act Concerning Standards for Health Care Provider Contracts

Good afternoon, Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee. My name is Christine Cappiello and I am the Director of Government Relations for Anthem Blue Cross and Blue Shield in Connecticut. I am here today to speak on **SB 16 An Act Concerning Standards In Health Care Provider Contracts.**

While we have met over the years with the CT State Medical Society at the direction of the Chairs of this Committee to work on issues that providers feel are of concern regarding contracting and in fact this Committee passed legislation in 2006 mandating those meetings, this seems to be a perpetual issue. It is important to remember that like any contract, these contracts are entered into by two sophisticated parties who enter into the negotiation willing and for mutual benefit. There is no other situation that I can think of where two sophisticated parties come to the Legislature to ask them to work out their differences and pick a side. And most importantly nothing in this bill benefits consumers of healthcare and in fact does nothing for consumers except raise the cost of the premium.

I would like to take a moment to speak to the specifics of this legislation that Anthem of concern. Section 2 of this bill seeks to have our regulator, the Insurance Department, set in statute the process and procedures for the health plan needed to have a network of providers. This is something that should be negotiated between the two sophisticated parties and not something that a regulator should be charged with doing.

Section 3 of this bill seeks to set in statute standards that are set by a national organization and requires health plans to maintain its network by the

organization's standards. This national organization's purpose is one of endorsement for quality rather than one of government regulation. Again, this is not something that should be set in statute but rather one that health plans should seek voluntarily. In addition, if those standards are modified, as they are from time to time, this Legislature would have to change the Connecticut General Statutes in order for health plans to be in compliance.

Section 4 of this legislation is perhaps the most egregious because it seeks to tie medical necessity determinations to payment. There are many reasons that initial medical necessity determinations should not be guarantees for payment for those services particularly since it is important to remember that those authorizations are given for a period of time, for instance six months or a year, rather than for just one day. Those situations which may prevent a payment from being made once an authorization period has been set are included but not limited to are things like: (1) Eligibility, (2) Coordination of benefits, (3) Benefit maximum or limits (4) In-network or out of network access and reimbursement, (5) frequency limitations, (6) Deductibles to mention a few. To legislature each and every situation would bring unintended consequences.

We respectfully as the Committee to reject this legislation and allow the contracting process that occurs between two sophisticated parties in almost every other situation continue.